

AN ANALYSIS OF THE UTILIZATION OF SELECTED PRESCRIBED MEDICAL SERVICES  
BY MEDICAID AND MEDICARE RECIPIENTS

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ABSTRACT  
SOCIAL WORK

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ANALYSIS OF THE UTILIZATION OF PRESCRIBED MEDICAL  
SERVICES BY MEDICAID AND MEDICARE RECIPIENTS

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The purpose of the study is to analyze the difference in the utilization of prescribed medications by Medicaid and Medicare recipients. This study examines problems many individuals in long-term care facilities face, when they are medicare recipients and unable to receive medical care which is as adequate as those who are beneficiaries of Medicaid.

This study involved thirty residents, divided equally into two groups. They resided in a small long-term care facility located in Fulton County (Georgia).

Findings revealed that Medicare recipients tend to visit their health providers less frequently, purchase fewer prescribed medications, and therefore, receive less adequate medical care than Medicaid recipients.

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## CHAPTER ONE

### INTRODUCTION

The need for adequate medical care and the lack of its receipt is a growing problem for the elderly and a concern of geriatric social services.

It is apparent that, despite available social security programs like Medicare and Medicaid a large proportion of the elderly population do not receive adequate medical care. People approaching old age, generally equate this period of life with retirement, relaxation, and selffulfillment. Unfortunately, many of the older population, over 60, are faced with the loss of health and the onset of chronic disease. Many elderly persons, according to Davidson and Marmor fear being incapacitated, dependent on others, institutionalized, or becoming financially destitute due to long-term disability and medical costs.

Therefore, instead of old age being equated with peace of mind, it is clouded with apprehension of disabling diseases which generally accompany the aging process.

According to a publication titled "The Elderly in the U.S.," elderly people aged 75 and above comprised only 29 percent of the population 65 years and over in 1900 and by 1970 the percentage grew to 38 percent. It is anticipated that by the year 2000 the percentage will be increased to 45. It could be said that the elderly population is aging within itself. This is due in part to the large birth cohorts of the late nineteenth and early twentieth centuries who have proceeded into advanced old age. Another factor is state-of-the-art medical

technology which improves life, as well as, prolong it. With this factor in mind, there are important implications for the delivery of health care.

Due to the fact that people are living longer, the incidence of chronic disease and functional impairments, as well as, utilization of health services dramatically increases starting at this time.

(Davidson and Marmor, 1980)

Unfortunately, however, only those with the means to solicit health services can benefit. It is this group which will be focused upon in the research.

#### Statement of the Problem

It appears that persons residing in long term care facilities who are Medicare recipients, do not utilize the same quantity of medical care services as do recipients of Medicaid. Residents receiving Medicare who do not have supplemental insurance, or additional resources, tend to neglect medical needs which are not covered by the program.

Due to the fact that people are living much longer, those in the age group of sixty and above must face the financial burden of health services. Because medical costs are so high, it is difficult for them to utilize the many services which may be needed. Also it is highly probable that the elderly are not utilizing health services to the fullest extent of their availability.

The focus of this research is to examine the extent that elderly are still not receiving adequate health services. The principal objective of this study is to compare the two programs, Medicare and Medicaid, and determine which program provides the greatest quantity of services.

Significance/Purpose of the Study

The purpose of this study is to formally investigate the utilization of medical care services by those individuals in a nursing care facility. More specifically, a comparison will be made between Medicare and Medicaid recipients to determine which group of recipients make more extensive use of medical services. Selected residents such as cancer victims are unable to try new experimental medications now being utilized to treat the disease because there are not enough funds available to cover the expense.

The author has observed that many persons with medicare, have less opportunity to utilize various medications or treatments, which could allow them a more satisfying life experience-- one more free of pain and suffering, due to the onset of chronic illness and disease. The primary beneficiaries of this study include medical doctors, nurses and especially social workers employed in long term care facilities need. They need to know the extent to which residents are receiving maximum care. It is also important that providers of care become more knowledgeable of existing gaps in the provision of services and how the gaps may be eliminated.

The purpose of this study was to determine the difference in medical care utilization by recipients of Medicaid and Medicare. Selected data suggested that medicare residents do not utilize medical services as readily as recipients of Medicaid.

Medicare recipients are personally responsible for costs the Medicaid group does not have. Namely, services such as transportation for routine physician visits, medicine costs, and physicians services which are needed

by the resident, are not covered in the benefits. Medicare covers only 44 percent of the medical expenses for this population. If these persons do not have supplemental income, they cannot utilize the service.

Medicare was designed to help the elderly population acquire medical services that they would otherwise be unable to obtain due to lack of economic resources and supplemental insurance. Medicaid on the other hand, was created to provide medical care to those persons with virtually no economic resources. While the two programs have similar goals: is there a significant difference between the two recipient groups and their pattern of utilizing medical services?

In an institution where the majority of clients are dependent upon a public agency for their complete resources, it is important to recognize which of the programs is the most instrumental in meeting the needs of its recipients.

## CHAPTER TWO

## REVIEW OF THE LITERATURE

## Overview of Major Theoretical Orientations

Limited Activities

In the area of limited activities, information derived from the National Center for Health Statistics surveys pointed out that as one ages, the percentage of persons in each succeeding age group, with activity limitations due to chronic conditions rises also. In addition, the average elderly person is twice as likely as a younger person to suffer from one or more chronic conditions. Consequently, the elderly person is more likely to be admitted to hospitals on a frequent basis, have longer stays, and utilize a doctor's service to a greater extent. (Davidson and Marmor, 1980)

Utilization of Services

In light of the fact that there is a high incidence of illness among the elderly, it follows that they would be heavier utilizers of medical services. The 1977 National Survey compiled by the National Center for health Statistics, discovered that 70 percent of persons aged 65 and over had seen a doctor within the past six months, this encompasses almost 13 percent more than for all other age groups. In addition, the average elderly person had 6.5 doctor visits during the year, compared to a mean of 4.6 visits for the other age groups.

Hospitalizations

In the area of frequent hospitalizations, 18 percent of the elderly population had at least one hospital stay in 1977,

compared to only 9.5 percent for other persons. The elderly had 27.5 discharges per 100 persons, which amounts to more than three times the rate for other age groups. And lastly, in the area of hospital duration, the average length of stay for the elderly was 11.1 days compared to 7 days for the other population. (Davidson and Marmor, 1980)

Elizabeth Hurlock, found in her research that due to the higher incidence of chronic disease conditions in the aged, more frequent hospital stays are the rule rather than the exception. She discovered that 1 person out of 6 aged 65 and above is hospitalized each year, and that the length of stay rises from 7 to 11 days for older adults when compared to other persons.

### Medical Care Expenditures

One method for determining heavy utilization of medical care is to review health expenditures. In 1977, the elderly represented 11 percent of the total population, but they accounted for 29 percent of personal health care expenditures. In addition, per capita expenditures for them was \$1,745, which comprised two and one half times adult below age 65, and seven times those for children under age 19. (Gibson and Fisher, 1979)

Despite the fact that the elderly account for large expenditures in health services, they are usually less financially equipped to assume the costs of medical services. With this in mind, it is necessary to look at the sources of payment for these expenses.

Despite the fact that the elderly account for a large expense in health services, they are usually less financially stable than younger individuals, and among the least well equipped financially to cope with the extremely high cost of medical expenses. In view of this, it is imperative to turn now to sources of payment for those services rendered.

Sixty seven percent of the medical bills incurred in 1977 were paid out of public funds, those being Medicare and Medicaid. The remaining 27 percent of the total, came directly from the resources of the elderly individuals and/or their families.

### Medicare

In looking at the medicare program itself, we find that it was created through the 1965 enactment of Title XVIII of the Social Security Act. It provides health insurance to persons aged 65 and above who are eligible for social security. (Oatman, 1978) Medicare's eligibility requirements and benefit structure are uniformed throughout the nation, and available without a regard to income or an individuals assets.

### Part A

Medicare is divided in two parts. Part A is available automatically to persons age 65, and those who become disable after they have been covered by Social Security Disability Insurance for a period of 2 years. It takes care of hospital services a total of 90 days after a \$260 deductible, 100 days of skilled nursing home care, and 100 home health care visits. It is this segment of Medicare



coverage that is financed primarily through a special hospital insurance payroll tax. (SSA, 1982)

### Part B

Medicare Part B is a voluntary program which is financed jointly through a monthly premium of \$11.00, which is paid by enrollees and federal taxes.

Persons 65 years of age or over and all those enrolled in Part A, have the option of enrolling in Part B. This coverage includes physician visits, laboratory and X-ray services, outpatient hospital care, and an available 100 home health care visits. Such benefits are obtainable only after this point, and then Medicare pays 80 percent of the reasonable charges for those services which are covered. (SSA, 1982)

Medicare does have flagrant deficiencies even though it covers several medically related needs. It fails to cover prescriptions, dental care, dentures, eyeglasses, hearing aids, or the examinations needed for the latter. Also routine foot care, and health examinations are among those services which are not covered. Lastly, custodial care, which involves private nursing, nursing home, and home care, is not covered. (Myers, 1970) This is an extremely important concern because the percentage of elderly who will need such institutions increases sharply with advancing age. The proportion increased from 2.1 percent of the 65 to 74 to 71.5 percent of those 75 to 84, and 19.3 percent of those of 85 and over (National Center of Health Statistics, 1978).

Regrettable, there are over 5 million elderly Americans who wear eyeglasses in need of correction; 3,500,000 elderly needing denture refitting or replacing; and 1,500,000 aged persons needing hearing aids or medical help for hearing problems. Unfortunately medicare has no provision to meet these needs. In addition, this population is most susceptible to chronic illness and, therefore, most likely to require long-term care. However, since Medicare is based towards acute short-term care, which is least utilized by the elderly, they are left with the burden of such expenses. (Pepper, 1980) The elderly are paying more for medical costs now, than when Medicare was created. Medical costs for those 65 are on the average, three times more, approximately \$1,800 annually than for younger persons, roughly \$600 annually. However, Medicare pays less than half of a person's medical expenses, which is about 44 percent. As a result, the elderly are likely to become fearful of becoming destitute, or becoming a burden on others for care. This fear leads to a false sense of security by the elderly, and can result in costly supplemental health insurance purchases. (Pepper, 1980)

### Coverage

Although Medicare does cover hospital costs, the proportion of covered physicians fees are diminishing. For those services which are covered, payments are increasingly insufficient because they are based on outdated fee scales and a limited view of what care a patient needs. Due to the fact that Medicare is system designed to pay bills as opposed to provide services, the bills get larger while the service get smaller. (Main, 1976)

The inadequacies of Medicare were grossly revealed by the Minneapolis Age and Opportunity Center, Inc., in 1973. Supported by funds and staff of Abbott-Northwestern Hospital a center invited the elderly to receive treatment regardless of the type of medical problem. These persons were assured in advance that there would be no charge for anything not covered by Medicare. This gave individuals an opportunity to gain medical attention who had been neglecting such for many years because of the cost. In only three months, over 8,000 people had registered. The staff and administration involved became very touched as they witnessed these persons, and the various pathologies. One client came in with a handkerchief over a cancerous hole in the cheek; while another had an abdominal aneurysm the size of a grapefruit. (Main, 1976)

Surprisingly enough, however, not all these patients were chronically poor. There were former doctors, lawyers, and other professionals, but they all had one thing in common. Even with Medicare, none could afford the cost of illness in old age. (Main, 1976) This experience is a prime example that the fear of medical expenses has caused the elderly in the U.S. to neglect their need for adequate medical care.

### Medigap

There are obvious gaps in medical costs for this population. This population is having to pay millions of dollars for numerous medical expenses in order to make up the difference between what their physicians charge and what Medicare designates as a reasonable charge for services rendered. The out of pocket costs which the

elderly must pay are referred to as "Medigaps." These "medigaps" have steadily increased over the years also, in 1969 it was a cost of \$81 million; in 1977 these patients had to pay a \$669 million difference between doctors fees and Medicares conception of reasonable charges. This was a 763 percent increase, with the greatest gaps in Medicare coverage being private nursing and medications. (50 Plus, 1979) To complicate this even further, it has now become more difficult to locate a physician that will accept Medicare assignments. Nationwide, assignment rates have dropped from 64 percent in 1967 to 50 percent in 1977. In some places these rates are dramatically reduced. Case in point, between 1969 and 1977, the assignment acceptance rate in Denver fell from 73 to 37 percent. In Seattle, the decrease was from 64 to 32 percent, and in Kansas City from 63 to 40 percent. (50 Plus, 1979) Medical Economics Magazine survey found that only one doctor in six never fails to accept Medicare assignments. Some never do, while others make the decision based on the particular case. (Ognibene, 1980)

It can be assumed that money is the primary reason few physicians take on such assignments, if refused, they have the privilege of charging patients whatever they think is reasonable. One recurring complaint by physicians is that Medicare fee schedules do not take into consideration the skyrocketing inflation in the medical field.

The date from which the Medicare fees are based range from 6 months to 2 and a half years old. (50 Plus, 1979) Case in point, a physicians office visit may be \$25.00, Medicare decides that a reasonable charge will be \$12.00-- of which Medicare will cover 80

percent or \$9.60. Therefore, this elderly patient must pay a difference of \$15.40. (50 Plus, 1980)

### Medicaid

Medicaid eligibility in addition to Medicare helps many elderly persons defray the high cost of medical treatment. Medicaid was created through the 1965 enactment of Title XIX of the Social Security Act. (Spiegel, 1979) It is a Federal State matching grant program, which provides medical assistance for low income persons who are aged, blind, disabled or members of families with dependent children.

The portion which the federal government pays is calculated by a formula based on the per capita income of the state. The federal government is committed to pay a minimum of 50 percent and a maximum of 83 percent. Each state governs its own program, and determines disability and the confines of benefits in the program. (Podair and Spiegel, 1975)

### Eligibility

Medicaid eligibility is based on the actual or possible receipt of financial assistance under federally assisted welfare programs. Furthermore, states may choose to cover medically needy persons. These include persons with income inadequate to purchase food, clothing or housing, but adequate enough to meet costs of medical care. (Myers, 1977)

### Services Provided

Medicaid mandates services for inpatient and outpatient hospital care, family planning, laboratory services, doctors fees, nursing

home care, and health care services for individuals under age 21. In addition, programs such as early periodic screening, diagnosis, dental care, mental health care, payment for prescription drugs, podiatry and chiropractor services, and prosthetic devices. These services are critical for its recipients. In 1976, 1 out of every 10 persons received medical services via Medicaid. This encompasses 2 million persons, who without it could not have obtained care. (Oatman, 1978 p. 80)

### Physician Visits

Just as Medicare has helped many elderly persons obtain medical care they may have had to do without, Medicaid has also made the same achievements. In regards to doctors visits per person per year prior to Medicaid, the poor had significantly fewer visits than non-poor individuals. Since the induction of Medicaid, the differences have diminished. (Myers, 1977)

### Statement of Theory

It seems as though lower income elderly persons in the U.S. are not as adequately protected by federal medical care programs as was once thought. Although Medicare and Medicaid programs provide many necessary medical needs, there still remains medical necessities which are characteristic and unique to this population which are not covered by the Medicare program.

It has been observed by this researcher in a nursing care facility that many of the residents do not have additional resources to cover medical needs which are very crucial for them. Many prescriptions,

doctors visits, or even ambulance services for needed treatment in the doctors office are not covered.

Primarily, those residents who are Medicare recipients are the ones with neglected medical needs. This is the case because the coverage is not adequate, and there are no additional resources to their need(s). For this reason, it is hypothesized that low income elderly residents who are medicare recipients do not receive adequate medical care.

#### Definition of Terms

##### Long-Term Care Facility

An institution which provides primarily for the continuing treatment of patients with long-term illness or with a low potential for recovery, and who require regular medical assessment and continuing nursing care. (Conference Report, 1987)

##### Skilled Nursing Facility

An institution which is primarily engaged in providing residents with a) skilled nursing care and related services for residents who require medical or nursing care, or b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, but is not primarily for the care and treatment of mental diseases. (Conference Report, 1987)

##### Intermediate Care Facility

An institution with general nursing supervision and assistance with eating, dressing, and other daily activities provided.  
(Conference Report, 1987 pp. 166-168)

Alzheimers

This disease is a form of dementia and represents a group of degenerative diseases of the brain in which mental deterioration is apparent in middle age. It encompasses four phases. The first is an impairment in judgement, followed by gradual memory loss. A progressive deterioration of physical appearance and personal hygiene will follow, and lastly, the command of language deteriorates (Mental and Health Encyclopedia, 1983 p. 417)

Dementia

This term represents mental deterioration with particular regard to memory and thought processes.

Resident

A person residing in a place.

Medical Care Services

The use of medical knowledge and services to relieve and/or cure medical problems.

Elderly

Persons age 65 and above.

Health Care Provider

Person or persons responsible for providing medical treatment.

Recipient

Person receiving financial or medical assistance from Medicaid or Medicare.

Beneficiary

Person that benefits from Medicaid or Medicare program.



Statement of Hypotheses

1. Residents of a nursing care facility who are recipients of Medicaid, utilized more of the medical services necessary for health maintenance, than residents with Medicare.

2. Medicare recipients visit their physician less often than Medicaid recipients.

3. Medicare recipients purchase fewer prescribed medications than Medicaid recipients.

## CHAPTER THREE

## METHODOLOGY

Research Design

The research design employed for the implementation of the study is an ex-post facto design.

Expost facto design is sometimes called causal-comparative. This design is focused at the discovery of possible causes for a behavior pattern by comparing subjects in whom this pattern is present, with similar subjects in whom it is absent or present to a lesser degree. (Borg and Gall, 1983 p. 533)

Sampling

In order to test the aforementioned hypotheses, a survey in the form of a questionnaire was used. The questionnaire contained direct questions devised to gather the necessary data for analyzing the utilization of selected prescribed medical services by Medicaid and Medicare recipients who were residents of a nursing care facility. A copy of the questionnaire is located in the appendix of this paper.

The facility has been in operation since 1979. It has the capacity to serve 120 persons. At the time of the survey, there were 112 residents. The facility has accommodations for Medicare, Medicaid, V.A. beneficiaries, and private pay status individuals.

The population of the residents is comprised of approximately 80 percent White and 20 percent Black. There is a ratio of approximately 6 to 1 in regard to sex; females representing the highest. The age range was between 31 and 97 years. Of the 112 residents, only a very small

percentage had any formal education beyond grade eight, or had been outside of the State of Georgia. That proportion was close to 24 percent.

The target population measured was a random sample of residents from a nursing care facility located in Southwest Atlanta. Thirty (30) participants were included in this study. Fifteen (15) clients who receive Medicaid, as well as fifteen (15) residents who are Medicare recipients.

The questionnaire was completed by the researcher through personal interviews with each participant.

#### Data Collection Procedure

Respondents were chosen randomly by means of the random numbers table. A census list which included all the current residents of the facility was utilized to help select the sample. From the table every fifth number was chosen. Each number corresponded with a room number. If there was no such room in the facility, the next fifth number was used.

Each response directly deals with the designated category. Questions 1 through 9 provided information regarding respondents social resources. Question 10 through 12, and 19 and 20 involved economic resources available to participants. Questions 13 through 15, and 27 addressed frequency of doctor visits and purchase of prescribed medications, and additional need for medical services. Questions 16 through 18 indicate the self-awareness of respondents regarding physical, emotional, and mental well-being. Upon collection of data, a T-Test was used.

Data Analysis

Table 1 represents demographic data of respondents. Of the female respondents there were 73.3 percent, while 26.7 percent were males. Seventy percent were caucasian while only 30 percent were Black. In the area of education, 13.3 percent of respondents completed high school while 33.3 percent had a post high school education. The highest proportion of those surveyed were widows (60.0), and the proportion of those receiving Medicaid and Medicare was equally distributed at 50.0 percent.

Table 2 on page 21, represents financial resources, and perceived need for additional resources of respondents. Of those receiving Medicaid, 66.7 percent responded positively, while 33.3 percent felt resources were insufficient. In addition, 60 percent of Medicare recipients stated the need for additional financial assistance, while only 40 percent of Medicaid recipients desired financial assistance above that received.

On page 22 Table 3 demonstrated the frequency of doctor visits, and purchase of prescribed medications. It is clear that Medicaid recipients frequently visit physicians (13.3%) and purchase prescribed medications (76.7%) more than the Medicare recipients. This could be attributed to the fact that these services are provided for and they are not responsible for out-of-pocket costs.

The table on page 24 (Table 4) indicates respondents perceived financial stability. Of those receiving Medicaid 56.7 percent felt resources were adequate for future needs, while only 43.3 percent of Medicare respondents felt needs were adequate for the future.

TABLE 1

T-Test Table for the Demographic Data of the Respondents

Variable	Frequency	Percent
1. SEX		
Male	8	26.7
Female	22	73.3
2. RACE		
White	21	70.0
Black	9	30.0
3. EDUCATION		
0-4 Years	2	6.7
5-8 Years	5	16.7
High School IN	9	30.0
High School	14	13.3
Post High	10	33.3
4. MARITAL STATUS		
Single	4	13.3
Married	4	13.3
Widowed	18	60.0
Divorced	4	13.3
5. MEDICAL COVERAGE		
Medicaid	15	50.0
Medicare	15	50.0

TABLE 2

Financial Resources and the Perceived Need for Additional Assistance

Variables	Frequency	Percent
1. Sufficient Resources		
Yes	20	66.7
No	10	<u>34.3</u>
	Sub Total	100.0
2. Financial Assistance Needed		
Yes	12	40.0
No	18	<u>60.0</u>
	Sub Total	100.0

TABLE 3

Medical Services Utilization

Variable	Frequency	Percent
1. Frequency of Doctors Visits		
Yes	4	13.3
No	26	<u>86.7</u>
		Sub Total 100.0
2. Purchase of Prescribed Medication		
Yes	23	76.7
No	7	<u>23.3</u>
		Sub Total 100.0

TABLE 4

Perceived Financial Stability

Variable	Frequency	Percent
1. Have Enough for Needs in the Future		
Yes	17	56.7
No	13	<u>43.3</u>
Sub Total		100.0



TABLE 5

Feelings About Life

Variable	Frequency	Percent
1. Overall excitement about Life		
Exciting	13	43.3
Routine	12	40.0
Dull	5	<u>16.7</u>
	Sub Total	100.0
2. General Satisfaction in Life		
Good	10	33.3
Fair	16	53.3
Poor	4	<u>13.4</u>
	Sub Total	100.0

Table 5 measured respondents overall feelings about life, in relation to excitement and general life satisfaction. Forty three point three percent found life exciting, while 40.0 percent felt it rather routine. A small percent (16.7) thought life at the facility was dull. In addition, 33.3 percent were satisfied with their present life status, 53.3 percent were fairly satisfied with life, and 13.4 percent were poorly satisfied.

The T-Test tables 6-11 located in Appendix B, revealed a statistically significant difference between the two groups. In Table 6, the scores demonstrated a significant difference at the .05 level of confidence between the two groups and their purchase of medications. Table 7 scores revealed a significant difference between groups in the area of need for additional funds. Tables 8 and 9 also demonstrated a significant difference between groups in regards to sufficient financial resources and frequency of doctor visits for treatment. Lastly, in tables 10 and 11 a statistically significant difference between groups was found in the areas of need for more medications than already receiving, and having enough needs in the future.

It can be inferred from each table, that the Medicaid group had more opportunity to receive medical care, as well as, utilize medical services than individuals receiving Medicare. These differences could be attributed to the high cost of medical care and the lack of financial resources on the part of individuals receiving government aid.

As the literature review pointed out: The elderly, are averaging longer hospital stays; if upon discharge there is need for custodial care as opposed to outpatient hospital care, or home health visits, those recipients whose financial resources are dependent on Medicare would not be able to utilize the medical services needed, unless there were provisions from another source. If a Medicare recipients condition warranted attention beyond the 100 days allotted for skilled nursing home care, unless there were additional resources, they would be unable to further utilize such a service. If Medicare recipients do utilize the physicians care, and obtain prescriptions for needed

medication, the possibility of the out-of-pocket costs exceeding their resources is high. This increasing dilemma can lead to decreased physician visits and neglecting to obtain necessary medications.

In addition, if a Medicare recipient has both part A and B, but need services to obtain eye, dental or ear care, such provisions are not addressed, if resources are not present such needs can go unattended and the particular problem progress.

Therefore, it can be concluded that a statistically significant difference exists between Medicaid and Medicare recipients in their purchase of prescribed medications, utilization of medical services, and routine visits to physicians. The research hypothesis is accepted, and the null hypothesis rejected.

## CHAPTER FOUR

## PRESENTATION OF RESULTS

In regards to substantiating each hypotheses in relation to the findings, it is safe to conclude that Medicare recipients; utilize medical services less, purchase fewer prescribed medications, and visit their physicians less often.

More than half (86.7%) of the Medicare respondents failed to see their physician on a regular basis. The explanation for this is due to the out-of-pocket costs they are required to pay which are not feasible on their budgets, and the lack of transportation coverage. Unless there is an additional source of finance, they will continue experiencing difficulty obtaining transportation service for a doctor visit. Such limitations prohibit the resident from meeting a critical need, therefore health conditions are neglected until they are at the point where the physician must come to the center, or the resident is sent to the hospital. If the resident had been able to utilize the physician service previously, the condition may not have progressed to the point of mandatory treatment.

The acquisition of medications is an area of great concern for the Medicare residents. When they receive prescriptions, there is a minimum charge for each item. For persons with limited resources, the out-of-pocket cost to them is not affordable. The consequences are the lack of receipt. There was only a small percentage of respondents (23.3) who were able to purchase prescribed medications: their explanation for this was "no money." Therefore, medications which could aid in health maintenance and prevention of future physical problems cannot be utilized.

In reference to medical care utilization, when respondents have additional needs which Medicare does not have provisions, and they perceive a need for supplementary allowances to provide needs uncovered, it follows that they are not getting all services desired. Because Medicare does not provide for ear, dental or eye examinations, and additional resources are not present, consequently, the service cannot be utilized.

There was a significant difference between Medicaid and Medicare recipients in their purchase of prescribed medications, utilization of medical services, and routine physician visits. Therefore, the research hypothesis is accepted, and the null hypothesis rejected.

## CHAPTER FIVE

## SUMMARY AND CONCLUSIONS

It could be inferred from this data that persons receiving Medicaid were in much better physical and mental condition, and utilized more services necessary for health care and maintenance. Because these respondents had consistent access to physicians, other medical services, and could purchase needed medications, the probability of them experiencing less physical and mental complications is high.

Medicare recipients are limited in terms of the type of services they can receive. They are faced with the probability of out-of-pocket costs for needed medications and doctor visits, which depending on their resources may not be feasible. If there is a sudden need requiring medical attention, and there are no surplus funds available to them the need cannot be met unless an additional source of funds are found. Residents on medicare in this facility, must be faced with the mental anguish of pondering how their needs will be provided if emergencies occur, and they have no resources.

Medicaid beneficiaries are able to enjoy their experiences and have a better sense of security by not being excessively concerned with how their needs will be met. Such residents, have an overall better feeling of satisfaction with life.

The results from this study were not surprising to the researcher because such incidents are observed each day. Medicaid residents are more content, have fewer limitations due to their health conditions, as well as, an overall positive outlook on their future.

Medicare residents, on the other hand, participate less in activities due to decreased physical mobility as a result of medical problems, which are not treated as frequently because of the high costs.

Medicare residents in the facility will go for long periods of time without purchasing their prescribed medications at the appropriate time, due to lack of supplemental resources to provide for the costs.

As clinicians, we are doing this population a great disservice. If there are individuals who have needs, it is our responsibility to meet that need; how can we be effective if such does not occur. This population has special characteristics and problems which are unique to them. It is difficult for such individuals to function as highly, or enjoy their life experiences when burdened with the issue of money. Many, express the desire to have Medicaid in order to ensure more adequate utilization of services. Unfortunately, they are not yet eligible. Therefore, the medical services they desire must be tabled until they acquire additional resources, or the opportunity arises that mandates care.

The implications of these types of problems are serious. What can be done to eliminate such issues. Are there not additional programs which could be instituted that could further assist these persons in meeting their needs.

These government programs have been in existence for 23 years. It is evident that at least one of them is accomplishing its original goal, but what about the other one? Evidence suggests a need for

revisions in order to ensure that Medicare's recipients are actually being helped to the fullest extent possible. The present plan has some obvious deficiencies. Due to the fact that the elderly population is increasing so rapidly, it would follow that implementation of programs to better serve them would be a priority.

The study gave concrete evidence that there is a very significant difference between services utilized by Medicare and Medicaid recipients.

#### Limitations of the Study

For the purposes of this study, the hypotheses were confirmed. The differences between Medicaid and Medicare in the areas of physician visits, medication purchases, and medical care utilization were statistically significant.

It is realized however, that sample size was relatively small. Had there been a larger sample population, the results could have been even more conclusive. Only thirty percent of the population was included.

If there had been more time and financial resources at the researchers disposal to donate to this study a more comprehensive study could have been conducted involving additional facilities, as well as, a state, region, or nationwide comparison. It was somewhat problematic being a student, working full-time, and conducting a survey in two weeks. This researcher felt very pressed for time, but was able to appropriately address the issue and achieve the desired goal.

In summary, the limitations did not adversely effect the findings of this study. The purpose was confirmed, and the results significant.



Suggested Research Directions

As mentioned earlier, as service providers it is important to find a means of providing necessary services to those individuals who are in need.

There is an obvious deficit: what can be done to close the gap between services provided and ample resources? A larger scale investigation of this issue, could provide even additional data to substantiate the hypotheses. This could undoubtedly lead to an implementation of a subsequent category to Title XIX, which would enable those persons on Medicare to obtain more of the services they may need, but which are currently not provided.

A more in depth look at the cost of care is also in order. Because costs are steadily increasing, and long term care for this population is a great risk, it would be very beneficial to investigate how costs can be kept to a minimum without decreasing the services provided.

## CHAPTER SIX

## IMPLICATIONS OF THE STUDY FOR SOCIAL WORK PRACTICE

As a result of this study, it is recommended that more comprehensive research be done in order to ascertain a more complete scope of this issue. More investigation of how Medicare recipients could obtain needed services is essential. If this federal program is not adequately meeting the needs of its population, what can be done to rectify this?

Implementation of screening programs could help eliminate the need for additional physician appointments that may exceed the budget of those with limited resources. The induction of such a program could identify potential problems before they progress to the point where treatment would be excessively high. This program would be most effective if it was courtesy-- at no charge to participants. The use of a preventive medicine practice could definitely be instrumental in saving money, prolonging life, and enhancing the overall quality of life for these persons.

The lack of transportation is also a factor for this group. The recipients of medicare do not have coverage for needed appointments. Therefore, many cannot go for dental, ear or eye exams. If, however, development and expansion of affordable, accessible transportation took place, the need could be met. If support could be provided to the Department of Human Resources Transportation Committee to encourage development of coordinated transportation systems, this population could utilize medical services needed.

An expansion of the services offered by Medicare would be an immediate resolution to several of the difficulties recipients face. Advocating for the inclusion of long-term care in Medicare

(Title XVIII) legislation or for a new title to do so, would aid recipients greatly. Also, supporting the continued reenactment and expansion of the Older Americans Act to encompass additional services and funding, could increase services to the elderly.

In Summary, any policy or program that would address the issue of providing additional resources, whether it be implementation of new programs, or the expansion of existing ones, this population would be positively effected.

# BIBLIOGRAPHY

## Articles

- Gap in Medicare, Medicaid, Constitute Financial Burden on Aged, (1979) Aging, July-August p. 38.
- Dextrader, Gail & Drennen, Nancy. (1985) "The Future of Medicare," Journal of Home Economics, Spring.
- How Well is Medicare Doing at Age 15? Report on Program Hems and Haues..., (1980), 50 Plus, October, p. 17.
- Elderly Americans Left Holding Bag in Dispute Over Medicare Assignments Cases, (1979), 50 Plus, July, p. 9.
- Fischer, Charles, & Gibson, Robert. (1979). Age Differences in Health Care Spending Fiscal year 1977, Social Security Bulletin, January.
- Main, Jeremy. (1976), What Ails Medicare. Money, May, pp. 44-47.
- Moseley, Jack. (1987), Caring for the Old, Elderly Challenge Lawmakers, Taxpayers, Southwest Times Record, December 13.
- Ognibene, Peter J. (1980), Is Medicare Doing More for Your Doctor Than You? 50 Plus, April, pp. 28-29.
- Pepper, Claude. (1980), Will there be a Brighter Tomorrow for the Nations Elderly? USA Today, May, pp. 14-15.

## Books

- Birchenall, Joan M. and Streight Mary Eillen. Care of the Older Adult. J. B. Lippincott Company 1982.
- Borg, Walter R. and Gall, Meredith D. Educational Research 4th ed., New York: Longman, 1983.
- Brabee, Weeks Berman. Financing of Health Care, Health Administration Press, 1979
- Davidson, Stephen and Marmor, Theodore, et al. The Cost of Living Longer. Lexington Massachusetts: Lexington Books, 1975.
- Hurlock, Elizabeth B. Ph.D. Developmental Psychology. McGraw-Hill, 1959.

Myers, Robert J. Medicare, McMahan Foundation Book Series. Homewood, Illinois: Richard D. Irwin, Inc., 1970.

The Medical and Health Encyclopedia, Chicago, Illinois: J.G. Ferguson Publishing Company, 1983.

National Institute on Aging, Our Future Selves, A Research Plan Toward Understanding Aging. Department of Health Education, and Welfare Publications No. 77-1096. Washington, D.C. United States Government Printing Office, 1977.

Oatman, Eric F. ed., Medical Care in the United States, New York: H.W. Wilson Company, 1978.

Podair, Simon and Spiegel, Allen, ed. Medicaid, Rockville, Maryland: Aspen Systems Corporation, 1975.

Robb, Susanne S. The Elderly in the United States Numbers, Proportions, Health, Status, and Use of Health Services, Appleton-Century Croft, 1980.

United States Department of Health and Human Services, Social Security Administration, Your Medicare Handbook, Baltimore, Maryland: SSA Publication, 1982.

## APPENDIX A

## Questionnaire

## 1. Sex of Subject

- 1 Male
- 2 Female

## 2. Race of subject

- 1 White (Caucasian)
- 2 Black (Negro)
- 3 Oriental
- 4 Spanish American (Spanish surname)
- 5 American Indian
- 6 Other

## 3. How old are you? \_\_\_\_\_

## 4. What is the highest level of education you completed?

- 1 0-4
- 2 5-8
- 3 High School incompleted
- 4 High School completed
- 5 Post high school, business or trade school
- 6 1-3 years college
- 7 4 years college
- 8 Post graduate college

## 5. What is your marital status?

- 1 Single
- 2 Married
- 3 Widowed
- 4 Divorced
- 5 Separated

## 6. How many people do you feel comfortable enough to visit?

- 3 Five or more
- 2 Three to four
- 1 One to two
- 0 None

## 7. Do you have people you can confide in and trust?

- 2 Yes
- 0 No

8. Do you find yourself feeling lonely?
  - 0 Quite often
  - 1 Sometimes
  - 2 Almost never
9. Do you see your relatives and friends as often as you would like to or are you somewhat unhappy about how little you see them?
  - 1 As often as wants to
  - 2 Somewhat unhappy about how little
10. What type of medical coverage do you have?
  - 1 Medicaid
  - 2 Medicare
11. Are your assets and financial resources sufficient to meet emergencies?
  - 1 Yes
  - 2 No
12. Is your financial situation such that you feel you need financial assistance or help beyond what you are already getting?
  - 1 Yes
  - 2 No
13. How often do you see your doctor for treatment?
  - 3 Bi-monthly
  - 2 One time a month
  - 1 Other
14. Do you purchase all medications prescribed?
  - 1 Yes
  - 2 No
15. Do you feel that you need more medical care beyond that which you are now receiving?
  - 1 Yes
  - 2 No
16. How would you rate your overall health at this time?
  - 4 Excellent
  - 3 Good
  - 2 Fair
  - 1 Poor



17. Is your health better now, about the same, or worse than it was 5 years ago?
- 3 Better
  - 2 About same
  - 1 Worse
18. How much do your health problems stand in the way of your doing the things you like to do?
- 3 Not at all
  - 2 Little
  - 1 Great deal
19. How well do you think you are doing financially as compared to others your age?
- 2 Better
  - 1 About the same
  - 0 Worse
20. Do you feel that you will have enough for your needs in the future?
- 2 Yes
  - 1 No
21. How often would you say you worry about things?
- 0 Very often
  - 1 Fairly often
  - 2 Hardly often
22. In general, do you find life exciting, pretty routine, or dull?
- 2 Exciting
  - 1 Pretty routine
  - 0 Dull
23. Taking everything into consideration how would you describe your satisfaction with life in general at the present time?
- 2 Good
  - 1 Fair
  - 0 Poor
24. Is your daily life full of things that interest you?
- 1 Yes
  - 2 No

25. How would you rate your mental and emotional health at the present time?
- 3     Excellent
  - 2     Good
  - 1     Fair
  - 0     Poor
26. Is your mental and emotional health better or worse or about the same as it was five years ago?
- 3     Better
  - 2     About the same
  - 1     Worse
27. Do you feel you need transportation more often than it is available to you now for appointments, visits, etc.?
- 1     Yes
  - 2     No

## APPENDIX B

TABLE 6

T-Test Table Showing Medicaid and Medicare on their Purchase  
of Medication

	Number	Mean	Standard Dev.	T-Value	D.F.	Prob
Group 1	15	1.00	0.000			
Medicaid						
				-3.50	28	0.002
Group 2	15	1.46	0.516			
Medicare						

-----

P< 0.002

TABLE 7

T-Test for Showing those in Need of Additional Funds

	Number	Mean	Standard Dev.	T-Value	D.F.	Prob
Group 1	15	1.266	0.458			
Medicaid						
				-4.91	28	0.000
Group 2	15	1.933	0.258			
Medicare						

---

P < 0.000

TABLE 8

T-Test Table Representing Sufficient Financial Resources

	Number	Mean	Standard Dev.	T-Value	D.F.	Prob
Group 1	15	1.000	0.000			
Medicaid						
				-5.28	28	0.000
Group 2	15	1.46	0.516			
Medicare						

-----

P< 0.000

TABLE 9

T-Test Table Depicting the Frequency of Doctor Visits for Treatments

	Number	Mean	Standard Dev.	T-Value	D.F.	Prob
Group 1	15	1.7333	0.458			
Medicaid						
				-2.26	28	0.032
Group 2	15	2.000	0.000			
Medicare						

-----

P < 0.032

TABLE 10

T-Test Table Representing the Need for More Medications Than Already  
Receiving

	Number	Mean	Standare Dev.	T-Value	D.F.	Prob
Group 1	15	1.000	0.000			
Medicaid						
				-3.50	28	0.002
Group 2	15	1.466	0.516			
Medicare						

-----  
P< 0.002



TABLE 11

T-Test Table for Having Enough Needs in the Future

	Number	Mean	Standard Dev.	T-Value	D.F.	Prob
Group 1	15	1.000	0.000			
Medicaid						
				-9.54	28	0.000
Group 2	15	1.866	0.352			
Medicare						

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P < 0.000

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